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What Every Lawyer Should Know About Medicare Coverage of Long-Term Care

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Lawyers today cannot be ignorant of healthcare problems. The subdivision of healthcare services and providers requires constant updating of the information lawyers need to know in this field.

A. Introduction

Given the anxiety that exists in our country today over the potentially ruinous financial effects of a long-term illness, it is surprising to find that there is a massive under-utilization of Medicare in the service categories that are of the most importance to those with long-term medical needs. Home health care, skilled nursing facility and hospice coverage under Medicare has been substantially, but quietly, improved over the last four years.[1] Unfortunately many individuals either don't know about the expanded coverage or lack the energy to ask for it, and thereby lose out.

What follows is a brief summary of the Medicare program and the recent improvements in long-term care, with some suggestions as to the role legal advocates can play in assisting their clients to realize these benefits promised in the Medicare law.

B. Medicare

Approximately 2.6 million New Yorkers have Medicare health insurance coverage, including virtually everyone age 65 or older. Medicare Part A covers institutional care (hospital and skilled nursing facility), hospice and home health care.[2] Part B, also known as Supplemental Medical Insurance or SMI, covers as much as 80% of physician's charges, out-patient care, ambulance and durable medical equipment services.[3]

Almost 10% of Medicare beneficiaries are under the age of 65.[4] These are individuals who are disabled and have collected at least 24 months of Social Security Disability benefit payments or individuals who quality for Medicare because they have end-stage renal disease (ESRD).[5] The per capita payments made on behalf of disabled participants are over 30% higher than for those who are eligible on the basis of age.[6] Enrollment into Medicare is virtually automatic except for individuals with ESRD. However, failure to apply timely for Social Security Disability benefits, or failure to establish an early onset date, will eliminate or delay Medicare participation for individuals qualifying based on their disability status.

Medicare is the primary medical insurance for those who are enrolled except where Congress has legislated otherwise. Payments due from group health plans, workers' compensation, no-fault and liability insurance may be expected to apply first, with Medicare next in line.[7] This does not lessen the scope of the coverage available to the individual, but may reduce the value realized from the primary payor.

Medicare does not provide comprehensive coverage for its enrollees. Medicare limits the specific services to be covered, (*e.g.*, prescriptions) and deductibles and co-payments apply to various categories of services covered. Within the service categories there are "level of care" requirements that may be used to deny a claim for benefits. The care level restrictions derive from the statutory exclusions of payment for services which are not "reasonable and necessary" or which are for "custodial care."[8] As a practical matter, it is clear that there is a strong dose of subjectivit in decisions regarding medical necessit and the initial decisions being rendere deny coverage in close cases.

FOOTNOTES

[1] None of these coverage improvements derive from the much publicized Medicare Catastrophic Coverage Act of 1988, P.L. 100-360 which expanded some benefits for the calendar year 1989. These expanded benefits were removed effective January 1, 1990. Medicare Catastrophic Coverage Repeal Act of 1989, P.L. 101-234.

[2] 42 U.S.C. § 1395d to § 1395i.

[3] 42 U.S.C. § 1395j to § 1395w.

[4] Rubin, J., Wilcox-Gok, V: *Health Insurance Coverage among disabled Medicare Enrollees.* Health Care Financing Review, Vol. 12, No. 4, p. 27 (Summer 1991).

[5] 42 U.S.C. § 1395c.

[6] See footnote 4, above.

[7] 42 U.S.C. § 1395y(b).

[8] 42 U.S.C. § 1395y(a). There are other bases for denying payment set out in this section, but the level of care requirements are by far the most common.

There is an appeals process to contest denials, which is rather complex, with as many as four levels of administrative review, but amazingly productive, with about half the cases at each level being awarded additional coverage.

The impact of Medicare coverage can be multiplied if your client has a private health insurance policy that covers long-term care services, as a number of policies do. Typically these insurers will rely on the Medicare standards to define their coverage responsibilities, and an uncontested, but wrong, Medicare denial will cost the client not just the Medicare coverage but their backup coverage also. Some of the state's larger employers have promised their retirees 730 days of skilled nursing facility coverage, but condition the coverage with the level of care standards used by Medicare.

An understanding of Medicare is necessary to assist your client in dealing with this system. That knowledge is also extremely important when you counsel a client about the means of gaining access to and paying for future care.

Once a solid analysis of the potential benefits has been done, much of the implementation can be handled by the client, or their family and friends. Many counties offer some help with understanding and dealing with insurers, through their Office for the Aging, Department of Senior Services or other service agencies for the elderly and disabled. The elected federal officials representing your client's area may be able to assist. Also, assistance can be purchased from private social work businesses and from businesses designed specifically for assisting with the paperwork involved with medical claims. With some reservations, one can also obtain assistance from the providers, especially the discharge planners or social workers.

C. Medicare's Expanded Coverage Standards

Three major components of long-term care covered by Medicare are home health care, skilled nursing care and hospice.[9]

1. Home Health Care

Home health care consists of physician-ordered nursing or therapy services provided to a person who is "homebound," with home health aide services added on. After a period of severely restricting coverage through the mid 1980's, Medicare was sued and found to have limited the home care benefit more than Congress had intended.[10] The District Court ordered new guidelines developed and in April, 1989 these were announced. The guidelines were issued in the form of an updated Medicare Home Health Agency Manual, more commonly known as HIM-11.[11] The new guidelines represent a significant expansion of coverage, from the general limits of no more than 9 hours of nursing and aide care per week, for no more than 6 weeks, to as many as 35 hours a week for as long as the need for therapy or nursing exists.

The skilled nursing care which qualifies one for Medicare coverage must be recurring, *i.e.*, a home visit at least once every 60 or 90 days. Full time nursing over an extended period of time would usually not qualify for Medicare coverage.[12] HIM-11 contains extensive examples of what constitutes skilled nursing care, including observation and assessment of a patient's condition, and management and evaluation of the patient's care plan along with the "hard" nursing services such as wound care and injections.[13]

Medicare provides coverage in full up to the limits of the program. There are no deductibles or co-payments. Should more care be required than can be covered by Medicare, other paying sources would be needed for the extra hours.

2. Skilled Nursing Facility Care

Patients who require daily skilled nursing care, or therapy five times a week which, as a practical matter, can

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FOOTNOTES

[9] These terms are defined in 42 U.S.C. § 1395x.

[10] *Duggan v. Bowen* 691 F. Supp. 1487 (D.C. Dist. of Columbia 1988).

[11] The Medicare regulations have not yet been revised to include the expanded coverage guidelines. The provisions of the HIM-11 can be found in the Commerce Clearing House Inc. Medicare and Medicaid Guide, by using the Finding List in Vol. 1 and locating §§ 203 through 206.

[12] HIM-11 § 205.1C.

[13] HIM-11 § 205.1B.

only be provided in a skilled nursing facility (SNF) should receive Medicare coverage for up to 100 days in a spell of illness.[14] Medicare will not pay for any skilled nursing care unless it is preceded by a minimum three day stay in a hospital.[15]

In the Spring of 1988 Medicare quietly announced a reinterpretation of its coverage standards and added cases involving skilled observation or management of a complicated or unstable condition. Thus an aggregate of unskilled care in an SNF suffices to establish Medicare coverage.[16]

While the first 20 days in an SNF are covered in full, there is a substantial co-payment involved for covered SNF days 21 through 100. The 1992 co-payment is $81.50 per day.

3. Hospice

Hospice can be described as a specialized program for patients who are terminally ill, *i.e.*, physician certified as having a life expectancy of no more than six months.[17] Hospice coverage includes counseling for the individual and their family, respite care and greater use of pain medication. Hospice became a covered service only in 1983. Until January 1, 1991 there was a limit on the number of days which Medicare would cover, but that has now been eliminated.[18] Hospice programs are being developed in many previously unserved areas, but access to a Medicare approved hospice program is by no means universal. Some programs offer primarily home care, while others regularly use hospital or nursing home beds.

The only out of pocket cost for this coverage is a co-payment of $5 or 5% (whichever is less) for prescriptions, and a 5% co-payment for the cost of institutional respite care.

D. Common Medicare Problems

1. Choosing a Provider

Medicare home care benefits can only be obtained if one receives services from a certified home health agency (CHHA). The application process, in fact, consists of calling a certified agency and requesting an assessment. The agency, with assistance from the individual, their family and the treating physician, will perform a medical and social assessment to determine the appropriateness of home care and the availability of Medicare coverage. Advocacy plays a role here. The agencies are guessing whether Medicare will actually pay for this care and that will be decided only by a retroactive review. Too many wrong guesses can result in a financial penalty. This reimbursement process has helped to dampen the agencies interest in taking on cases that go beyond the limited coverage available in the pre-*Duggan* world. Working with the agency in reviewing HIM-11 may be productive. In other cases, getting an opinion from another certified agency will accomplish your goal.

As noted above, the hospice benefits must come from a Medicare approved hospice program.

2. Mandatory Notice of Non-Coverage from the Provider

When Medicare determines that a service was not "reasonable and necessary," the provider may be prohibited from collecting any payment from the patient unless that individual could reasonably have been expected to know that Medicare payment would not be made for that service.[19] The regulations implementing this statute provide standards rather favorable to the individual.[20] The provider must give notice if they believe that any service might not be covered by Medicare, with specific reasons listed for the expected denial. This notice requirement applies to Part A and physician services.

It must be made clear to your client that this notice is primarily for the purpose of protecting the provider, and does not constitute a final Medicare determination. The notice must state the next step to be taken to keep the claim alive.

3. Be Sure the Provider Respects the Medicare Billing Limits

Federal and state law impose various limits on the amount a provider can charge a Medicare participant for covered care.[21] These limits don't have direct application to nursing home or home health care in general, but the limits which apply to hospital stays are of relevance to long-term care patients since they are likely to spend some time in the hospital.

A Medicare participant cannot be held personally liable for more than $5,542 for a ninety day 1992 hospital stay which meets the coverage standards, no matter how expensive the treatment which is provided.[22] That same dollar limit would apply to repeated admissions which occur within one spell of illness, so that the maximum billable amount for each stay would be even less.

FOOTNOTES

[14] 42 U.S.C. § 1395f(a)(2)(B).
[15] 42 U.S.C. § 1395x(i).
[16] See 42 C.F.R. §§ 409.20 to 409.36.
[17] See 42 C.F.R. §§ 418.20 to 418.30.
[18] § 4006(a) of the Omnibus Budget Reconciliation Act of 1990, Pub. L 101-508.
[19] 42 U.S.C. § 1395pp(b), 42 U.S.C. § 1395u(l).
[20] See *e.g.*, 42 C.F.R. § 411.404.
[21] Physicians are limited as to the amount they can bill or collect in several ways. See *e.g.*, 42 U.S.C. § 1395u(b)(3) (physician who accepts assignment must accept the Medicare determined reasonable charge as payment in full); NY Pub. Health Law § 19, (maximum billing for non-participating physicians set at 115% of Medicare's reasonable charge) 42 U.S.C. § 1395u(l) (federal maximum billing limit).
[22] 42 C.F.R. § 412.42 caps the personal liability of a Medicare participant at the total of the in-patient hospital deductible ($652 for 1992) plus the co-payment amount which applies to hospital days 61 to 90 of any spell of illness ($163 per day for 1992) as long as the patient hadn't exhausted his or her Medicare in-patient coverage as of the day of admission. This limit stems from the use of the Prospective Payment System for reimbursing hospitals by Medicare. The hospital gets paid an average amount for the particular diagnosis assigned to a patient, no matter the cost of a particular case. Thus the cost of furnishing services to the individual patient is irrelevant in the Medicare payment system.
It could be argued that the Diagnosis Related Group (DRG) payment made by Medicare should, if less than $5,542, serve as the cap on personal liability. The Medicare provision establishing the deductibles and co-payments, 42 U.S.C. § 1395e, strongly suggests such a result, but Medicare has not adopted that interpretation. The Fiscal Year 1992 National Adjusted Standardized Amount for a Large Urban Area is $3,567.81. This national average DRG payment is adjusted by an area wage index and multiplied by the relative weight for the relevant DRG classification to determine the Medicare payment for a specific patient. 56 F.R. 43196 (Aug. 30, 1991).

4. See That Every Claim Gets Submitted

This seemingly simple step is not automatic, except where required by statue.[23] Nursing homes and home health care agencies may need some assistance and direction in this regard.

The most severe problem with failures to submit occur at skilled nursing facilities (SNFs). For many SNFs in New York, the Medicare reimbursement rates are little different than the amount paid by Medicaid, and both are substantially less than the private pay rate. This gives the nursing homes very little incentive to submit Medicare claims. Furthermore, unless they protected themselves by informing the patient of possible Medicare non-coverage, the SNF may lose the option of collecting payment from the client in the event of a Medicare denial.

The SNF must submit the Medicare claim if requested to do so.[24] While the coverage available from Medicare isn't great, (20 days of full coverage, then 80 days with a patient co-payment of $81.50 per day) it is a start and can perhaps be leveraged with a private insurance policy.

E. Medicare Appeals

The initial Medicare coverage determinations are made by fiscal intermediaries (Part A) or carriers (Part B). These entities are large insurance companies that have contracted with Medicare to administer the Medicare claims process.

There is a good deal of discretion involved in making the coverage determinations. To correct errors, and provide some measure of consistency and fairness, an appeals process exists for each Medicare Part.

For Part A, the appeals process is:

1. Reconsideration
2. Administrative Law Judge (ALJ) hearing ($100 minimum)
3. Appeals Council
4. Federal Court ($1,000 minimum)

The following table sets out the percentage of determinations at each level, excluding dismissals and withdrawals, which resulted in a full or partial determination favorable to the claimant during fiscal year 1990:

Part A Reversal Rates

	Nationally	New York
Reconsideration	52.1%	41%
ALJ	75.9%	61%

For Part B, a carrier review and a separate carrier hearing replace the reconsideration step. The dollar threshold increases to $500 for ALJ hearings. The reversal rates are comparable to Part A. These statistics do not include the reversal rate for cases taken to federal court, but an informal estimate would be at least 50%.

1. Reconsideration and Review

An initial Medicare denial should not be taken too seriously. Medicare seems to understand this. The procedure for appealing the initial denial, called reconsideration under Part A, consists of obtaining a second opinion on the submission. A reviewer of the same rank as the initial decision maker, with the exact same file and information, takes another look at the claim. As noted above, about one-half of the time additional coverage is provided on reconsideration. The work involved in winning this additional coverage consists of writing a one line letter, sent within the 60 day deadline.

2. ALJ Hearing

The Administrative Law Judge (ALJ) hearing is a full review of the case, with opportunity to develop the record. The single most important addition to the file, where the level of care is at issue, would be a letter from the client's treating physician providing her/his reasons for concluding that

a. care was medically "reasonable and necessary,"

b. required the direct involvement of medical professionals to ensure the patient's safety, and

c. was provided at the most appropriate level *e.g.*, hospital, skilled nursing facility, or home.

The Second Circuit has come very close to holding that the "treating physician rule" used in disability cases also applies to Medicare appeals.[25] The rule provides that the medical opinion of the patients' treating physician is

i) binding on the fact-finder unless contradicted by substantial evidence and

ii) entitled to some extra weight due to the familiarity with the claimant's medical condition.[26]

The ALJ hearing can be a full-blown de novo in-person hearing, but in some cases that is not required. The level of care determination will rest on the medical records, supplemented by the physicians' statement, and on occasion by testimony from the patient or other witnesses. An advocate will want to summarize the medical evidence and relate it to the proper decisional standards, but this may be done through a written submission rather than a personal appearance.

The average recovery, as reported by several projects that specialize in Medicare appeals, is in the range of $5,000. They also report that they can cover their costs with a contingency fee of less than 20%. The representation does not have to be done by an attorney, in fact many ALJ hearings are done pro se. However, it is helpful to have a trained advocate, such as a paralegal, make the presentation at the hearing and/or prepare the written submission.

Fees for representation at the administrative level are generally limited to 25% of the Medicare benefits recovered.[27]

3. Federal Court

In federal court proceedings both the factual conclusions and the legal

FOOTNOTES

[23] Initial submissions to Medicare by hospitals are done routinely. Since September 1, 1990 Medicare Part B providers, such as physicians and ambulance services, are required to submit Medicare claims for their patients and are prohibited from directly charging for that work. 42 U.S.C. § 1395w-4(g)(4).

[24] *Sarrassat v. Sullivan* (C 88 20161, N.D. Cal. 1989).

[25] *State of N.Y. on Behalf of Holland v. Sullivan* 927 F. 2d 57 (2nd Cir. 1991) *State of N.Y. on Behalf of Stein v. Secretary of Health and Human Services* 924 F. 2d 431 (2nd Cir. 1991). One federal district court has adopted the rule. *Klementowski v. Secretary*, ___ F. Supp. ___, 1992 WL 247027 (W.D.N.Y. Sept. 9, 1992).

[26] *Schisler v. Heckler*, 787 F. 2d 76, 81 (2d Cir. 1986).

[27] 42 U.S.C. 406(a)(2)(a), 20 C.F.R. § 404.1720.

conclusions of the Secretary can be reviewed, although under two different standards.

With respect to the Secretary's legal conclusions, or more generally his application of legal principles, judicial review is de novo.[28] Where evidence is not properly evaluated because of a misapplication or erroneous view of the law, the Secretary's decision cannot be upheld.[29] The application of the "treating physician rule" comes into play in this evaluation.

The review of factual findings is restricted to the "substantial evidence" test. In determining what constitutes substantial evidence, the reviewing court must look to the record as a whole, not merely the evidence which supports the Secretary's decision.[30] As the Second Circuit has held, "in assessing whether the evidence supporting the Secretary's position is substantial, we will not look at that evidence in isolation but rather will view it in light of other evidence that detracts from it."[31]

In cases that win after an appeal to federal court, where the government's position is found to be not substantially justified, attorney's fees paid by the government can be awarded under the Equal Access to Justice Act (EAJA).[32] The fee awards, based on prevailing rates, will include the time spent on the federal court case and any subsequent administrative hearings held on remand.

Conclusion

There is a great deal of good work that legal advocates can do within the Medicare system. The results will be to extend the coverage from this primary source, significantly decreasing out-of-pocket costs, providing a greater choice of medical care options and delaying or avoiding the need to apply to Medicaid.

[28] *Townley v. Heckler*, 748 F. 2d at 112; *Marcus v. Califano*, 615 F. 2d 23, 27 (2d Cir. 1979); *Speria v. Heckler*, 587 F. Supp. 1279, 1282 (S.D.N.Y. 1984).
[29] *Smith v. Bowen*, 687 F. Supp. 902, 904-05 (S.D.N.Y. 1988); *Ceballos v. Bowen*, 649 F. Supp. 693, 698 (S.D.N.Y. 1986).
[30] *Hurley v. Bowen*, 857 F. 2d 907, 912 (2d Cir. 1988); see also *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474,e488 (1951).
[31] *State of New York on Behalf of Bodnar v. Secretary of Health and Human Services*, 903 F. 2d 122, 126 (2d Cir. 1990).
[32] 28 U.S.C. § 2412(d)(1)(A).

President's Message

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harassment. The Executive Committee of our Association has encouraged law firms to review existing policies concerning childbirth and parenting leave and have urged these firms to adopt fair written policies. Ad hoc responses to such requests are hard on all concerned. Written measures benefit not only the attorney seeking the leave but also the firm and all its members.

Most recently, and probably within the past two years, the Young Lawyers Section has grown in numbers and strength and it too has been active in meeting the challenges of locating positions, networking and other concerns created by a recessionary economy. Among initiatives for law students, members of the Labor and Employment Law Section share their experience in getting started, employment options and issues of concern in their field, through their presentations to students at the various law schools. The Committee on Legal Education and Admission to the Bar conducts an annual law student legal ethics award program in conjunction with the state's law schools to encourage and recognize research and activities concerning professional ethics. The Committee recently suggested that there should be changes made in the appeals process surrounding the bar examination.

This is certainly not an exhaustive description of all our actions to promote professionalism. While they are wide-ranging and tailored to meet diverse needs, all these activities have a common element— the involvement of our members. Anyone who believes that dedication to the good of the profession is an anachronism should sample these programs and resources. They would quickly see an outpouring of volunteerism and selfless sharing of knowledge to ensure that the finest traditions of the profession are preserved while addressing contemporary conditions. Our work is ongoing and I invite your active participation and suggestions.